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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2310

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02292

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Edw. W. McCready Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Josephine Brittingham</b>		4. DATE OF DEATH <b>February 21 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-14-1889</b>
9. AGE (In years last birthday) yrs. <b>69</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>21 15 59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Merritt</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Lasbury</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No None</b>		16. SOCIAL SECURITY NO. <b>E. J. Brittingham, Westover, Maryland</b>	
17. INFORMANT <b>E. J. Brittingham, Westover, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>174X Coma Acute Dist of Heart</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Artery Disease</b>			
(c) <b>2 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>myocardial infarction</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1956</b> to <b>Feb 21, 1959</b> , that I last saw the deceased alive on <b>Feb 20, 1959</b> , and that death occurred at <b>1:05 AM</b> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>George C. Coulbourn</b> M.D. <b>Marion Station, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>George C. Coulbourn, M.D. Marion Station, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-23-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 27 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>			

CERTIFICATE OF DEATH

1910

Page 1 of 1

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 1, 1865		New York City	
Cause of Death		Disease		Duration		Time of Day		Place of Death	
Heart Disease		Myocardial Infarction		2 weeks		10:30 AM		Home	
Occupation		Profession		Education		Marital Status		Religion	
Teacher		Teacher		High School		Married		Roman Catholic	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Death		Time of Death		Place of Death		Cause of Death		Disease	
Jan 15, 1910		10:30 AM		Home		Heart Disease		Myocardial Infarction	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02293

2311

FOR STATE  
HEALTH DEPT.

## 1. PLACE OF DEATH

a. COUNTY

Somerset

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Pocomoke City R. F. D.

c. LENGTH OF STAY IN 1b

5 Years

## 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Somerset

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Pocomoke City R. F. D.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

d. STREET ADDRESS

e. IS RESIDENCE  
ON A FARM?  
YES ☒ NO ☐3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

Wilbert J. Cornish

4. DATE  
OF  
DEATH

Month

Day

Year

February

12

19 59

## 5. SEX

Male

## 6. COLOR OR RACE

Negro

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

## 8. DATE OF BIRTH

April 6, 1906

9. AGE (In years  
last birthday)

52 yrs.

## IF UNDER 1 YEAR

Months

Days

## IF UNDER 24 HRS.

Hours

Min.

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

## 10b. KIND OF BUSINESS OR INDUSTRY

Lumber

## 11. BIRTHPLACE (State or foreign country)

Maryland

## 12. CITIZEN OF WHAT COUNTRY?

U. S. A.

## 13. FATHER'S NAME

Olie Waters

## 14. MOTHER'S MAIDEN NAME

Esther Cornish

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)

No

(If yes, give war or dates of service)

## 16. SOCIAL SECURITY NO.

218-14-4546

## 17. INFORMANT

Frank Cornish

## Address

Eden, Maryland

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Myocardial Failure

INTERVAL BETWEEN  
ONSET AND DEATH  
2 Mo.

241X

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

Asthma

DUE TO

(c)

4 Yrs.

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)

19. WAS AUTOPSY  
PERFORMED?  
YES ☐ NO ☒20a. EXTERNAL CAUSE WAS  
PRIMARY ☐ or CONTRIBUTING ☐  
CAUSE OF DEATH.

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY  
Month, Day, Year  
Hour a. m.  
p. m.

19

20d. INJURY OCCURRED  
While at work ☐ Not while at work ☐20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

## 20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐ACTUAL  
SIGNATURE

R. H. Johnson

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

Feb. 14, 1959

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

## 22b. DATE THEREOF

2/15/59

## 22c. NAME OF CEMETERY OR CREMATORY

FLOWERS HILL

## 22d. LOCATION (City, town, or county)

EDEN

(State)

MARYLAND

## 23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

WILLIAM H. JAMES JR PRINCESS ANNE, MARYLAND

## 24a. REC'D BY REGISTRAR

FEB 16 '59

## 24b. REGISTRAR'S SIGNATURE

Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MISSISSIPPI  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MISSISSIPPI  
STATE DEPT. OF HEALTH  
BUREAU OF VITAL STATISTICS

<p>1. NAME OF DECEASED: _____</p>	
<p>2. SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female</p>	
<p>3. AGE: _____</p>	
<p>4. DATE OF DEATH: _____</p>	
<p>5. PLACE OF DEATH: _____</p>	
<p>6. CAUSE OF DEATH: _____</p>	
<p>7. MANNER OF DEATH: _____</p>	
<p>8. SIGNATURE OF EXAMINER: _____</p>	
<p>9. PRINTED NAME OF EXAMINER: _____</p>	
<p>10. TITLE OF EXAMINER: _____</p>	
<p>11. COUNTY: _____</p>	
<p>12. CITY: _____</p>	
<p>13. STATE: _____</p>	
<p>14. ZIP CODE: _____</p>	
<p>15. TELEPHONE: _____</p>	
<p>16. HOURS OF DEATH: _____</p>	
<p>17. DAY OF DEATH: _____</p>	
<p>18. MONTH OF DEATH: _____</p>	
<p>19. YEAR OF DEATH: _____</p>	
<p>20. SIGNATURE OF WITNESS: _____</p>	
<p>21. PRINTED NAME OF WITNESS: _____</p>	
<p>22. TITLE OF WITNESS: _____</p>	
<p>23. COUNTY: _____</p>	
<p>24. CITY: _____</p>	
<p>25. STATE: _____</p>	
<p>26. ZIP CODE: _____</p>	
<p>27. TELEPHONE: _____</p>	
<p>28. HOURS OF DEATH: _____</p>	
<p>29. DAY OF DEATH: _____</p>	
<p>30. MONTH OF DEATH: _____</p>	
<p>31. YEAR OF DEATH: _____</p>	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE STATE DEPT. OF HEALTH, BUREAU OF VITAL STATISTICS, AT THE CAPITAL CITY, JACKSON, MISSISSIPPI.

Item 18 Film 239 3-10-59 ams

CERTIFICATE OF DEATH

Reg. Dist. No.

02294 265-

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cristfield</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westover x</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>McCreedy M. Hospital</b>		d. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) <b>Lillian M. Dashiield</b>		4. DATE OF DEATH <b>2 27 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 2, 1931</b>
9. AGE (In years last birthday) <b>27</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Westover</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Raymond Dashiield</b>		14. MOTHER'S MAIDEN NAME <b>Dorothy Handy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>PT. 1</b>	
17. INFORMANT <b>Mrs. Dorothy Dashiield - Westover, Md.</b>		Address <b>PT. 1</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] (Eclampsia) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Eclampsia - acute nephritis - 642.1</b> DUE TO (b) <b>2 days</b> DUE TO (c) <b>2 days</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Feb. 25, 1959</b> , to <b>Feb. 27, 1959</b> , that I last saw the deceased alive on <b>Feb. 27, 1959</b> , and that death occurred at <b>11:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>George C. Coulbourn</b> M.D.		ADDRESS (Street, city or town, state) <b>MARION STATION Md.</b> DATE SIGNED <b>3-2-59</b>	
PHYSICIAN'S NAME (Type) <b>GEORGE C. COULBOURN MD.</b>		<b>MARION STA. MARYLAND.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/2/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Westover</b>	22d. LOCATION (City, town, or county) (State) <b>Westover, Som. Co. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles H. Ward</b>		ADDRESS <b>Marion St., Md.</b>	
24a. REC'D BY REGISTRAR <b>MAR 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hearn</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





02295

2313

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>				c. LENGTH OF STAY IN 1b <b>17 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westover</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>McCready Memorial Hospital</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Birdie</b> Middle <b>Mae</b> Last <b>Doyle</b>				4. DATE OF DEATH Month <b>February</b> Day <b>20</b> Year <b>19 59</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/30/1886</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>George Price</b>				14. MOTHER'S MAIDEN NAME <b>Celia Jane Mackmeans</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Talmage Doyle, Princess Anne, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Embolus - Degenerative (years)</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Heart Condition</b> (c) <b>General Arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b> <b>years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>Dec. 1958</b> to <b>Feb. 22, 1959</b> , that I last saw the deceased alive on <b>Feb. 20, 1959</b> , and that death occurred at <b>12:00 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Princess Anne, Md.</b> DATE SIGNED <b>2-20-59</b>							
ACTUAL SIGNATURE <b>George C. Coulbourn M.D.</b>				PHYSICIAN'S NAME (Type) <b>GEORGE C. COULBOURN M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>				22b. DATE THEREOF <b>2/22/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Andrews</b>	
22d. LOCATION (City, town, or county) (State) <b>Princess Anne, Maryland</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>James L. Linnin</b>				ADDRESS <b>Princess Anne, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 25 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2303

## CERTIFICATE OF DEATH

Reg. Dist. No.

02296

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>11 S. Fifth St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>INFANT</b> Middle <b>BOY</b> Last <b>FOSQUE</b>		4. DATE OF DEATH Month <b>February</b> Day <b>13</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 12, 1959</b>
9. AGE (In years last birthday) <b>No</b> yrs.		10. IF UNDER 1 YEAR Months <b>No</b> Days <b>12</b> Hours <b>12</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Crisfield, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles E. Steward, Jr.</b>		14. MOTHER'S MAIDEN NAME <b>Emily F. Fosque</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Emily F. Fosque, 11 5th St., Crisfield, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>776x</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 12, 1959</b> , to <b>Feb 13, 1959</b> , that I last saw the deceased alive on <b>Feb 12, 1959</b> , and that death occurred at <b>7:15 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crisfield, Maryland</b> DATE SIGNED <b>2/15/59</b>			
ACTUAL SIGNATURE <b>Sarah M. Peyton</b> M.D. <b>33 W. Main</b>		DATE SIGNED <b>2/15/59</b>	
PHYSICIAN'S NAME (Type) <b>SARAH M. PEYTON, M. D.</b>		<b>Crisfield, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-14-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lawsonia Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Crisfield, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Maryland</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>FEB 17 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

02297

2314

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Princess Anne</b>		c. LENGTH OF STAY IN life <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Woodland Jackson</b>		4. DATE OF DEATH <b>February 1</b> 19 <b>59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 20, 1882</b>
9. AGE (In years last birthday) <b>76</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmed Store Keeper</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Adolphus Jackson</b>	
14. MOTHER'S MAIDEN NAME <b>Josephine Simms</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Marion Jackson</b> Address <b>Mt. Vernon, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>cerebral arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>  <b>years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 17</b> , 19 <b>59</b> , to <b>Feb 1</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Feb 1</b> , 19 <b>59</b> , and that death occurred at <b>5:30</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Dames Quarter, Maryland</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Everett C. Sutter</b> M.D.		PHYSICIAN'S NAME (Type) <b>Everett C. Sutter MD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/4/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Asbury Methodist</b>	22d. LOCATION (City, town, or county) (State) <b>Mt. Vernon, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Everett C. Sutter</b> ADDRESS <b>Princess Anne, Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 6 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02298

2304

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN lb <b>Lifetime</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>324 Tyler St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>ALONZO</b> Last <b>PAIGE</b>		4. DATE OF DEATH Month <b>February</b> Day <b>21</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 6, 1955</b>
9. AGE (in years last birthday) <b>4</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Crisfield, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Charles Miles</b>	
14. MOTHER'S MAIDEN NAME <b>Lucy Paige</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Lucy Paige, 324 Tyler St., Crisfield, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Accidentally burned to death in dwelling fire.</b> 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Body burned to charcoal.</b> DUE TO (c) <b>Arms and legs burned off. (partly)</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Dwelling fire.</b>	
20c. TIME OF INJURY Month, Day, Year <b>5:00 a.m. 2-21-19 59</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) (County) (State) <b>Crisfield, Somerset, Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>William H. Coulbourn</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> FOR SOMERSET COUNTY, MD.	
EXAMINER'S NAME (Type) <b>William H. Coulbourn, M. D.</b>		DATE SIGNED <b>2-22-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-22-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lawsonia Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 27 '59</b>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Howard</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2302

FOR STATE  
HEALTH DEPT.

30

11





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 2/57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
2305 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02299

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>	c. LENGTH OF STAY IN 1b <b>Lifetime</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>324 Tyler St.</b>		d. STREET ADDRESS <b>324 Tyler St.</b>	
3. NAME OF DECEASED (Type or print) First <b>DIANE</b> Middle <b>LOUELLA</b> Last <b>PAIGE</b>		4. DATE OF DEATH Month <b>February</b> Day <b>21</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 11, 1950</b>
9. AGE (In years last birthday) <b>8</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Crisfield, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Miles</b>		14. MOTHER'S MAIDEN NAME <b>Lucy Paige</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Crisfield, Md. (Lucy Paige 324, Tyler St.)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Accidentally burned to death in dwelling fire.</b> <b>916.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Body burned to charcoal.</b> (a), stating the underlying cause last. DUE TO (c) <b>Armes and legs burned off. (partly)</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Dwelling fire.</b>	
20c. TIME OF INJURY Month, Day, Year <b>5:00 a.m. 2-21-1959</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Crisfield, Somerset, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> <b>William H. Coulbourn, M.D.</b> ACTUAL SIGNATURE <b>William H. Coulbourn</b> M.D. CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER <b>2-22-59</b> FOR SOMERSET COUNTY, MD. EXAMINER'S NAME (Type) <b>William H. Coulbourn, M.D.</b> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-22-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lawsonia Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 27 '59</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
2208 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH OFFICE

DATE OF DEATH  
COUNTY

DECEASED

RESIDENT

DECEASED

DECEASED

RESIDENT

DECEASED

DATE OF DEATH

DATE OF DEATH

DECEASED

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
2306 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02300

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>324 Tyler St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARY LUCILLE PAIGE</b>		4. DATE OF DEATH <b>February 21, 19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 6, 1948</b>
9. AGE (In years last birthday) <b>10</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Crisfield, Md.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>Charles Miles</b>		14. MOTHER'S MAIDEN NAME <b>Lucy Paige</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Lucy Paige, 324 Tyler St., Crisfield, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Accidentally burned to death in dwelling fire.</b> <b>916.0</b> DUE TO (b) <b>Body burned to charcoal.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Arms and legs burned off. (partly)</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Dwelling fire.</b>	
20c. TIME OF INJURY Month, Day, Year <b>5:00 a.m. 2-21-59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Crisfield, Somerset, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>William H. Coulbourn</b>		M.D. CHIEF MEDICAL EXAMINER <b>William H. Coulbourn</b> DATE SIGNED <b>2-22-59</b>	
EXAMINER'S NAME (Type) <b>William H. Coulbourn, M. D.</b>		DEPUTY MEDICAL EXAMINER <b>FOR SOMERSET COUNTY, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-22-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lawsonia Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>FEB 27 '59</b>		DATE	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>			



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02301

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>39 Crisfield</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>324 Tyler St.</b>			d. STREET ADDRESS <b>324 Tyler St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ORVILLE</b> Middle <b>ANTONIO</b> Last <b>PAIGE</b>			4. DATE OF DEATH Month <b>February</b> Day <b>21</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 29, 1959</b>		9. AGE (In years last birthday) <b>No</b> yrs. <b>No</b> Months <b>22</b> Days <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Crisfield, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Charles Miles</b>		
14. MOTHER'S MAIDEN NAME <b>Lucy Paige</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT <b>Lucy Paige, 324 Tyler St., Crisfield, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Accidentally burned to death in dwelling fire.</b> 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Body burned to charcoal.</b> (a), stating the underlying cause last. DUE TO (c) <b>Arms and legs burned off. (partly)</b>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Dwelling fire.</b>			
20c. TIME OF INJURY Month, Day, Year <b>5:00 a.m. 2-21- 1959</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
20f. (City or town) <b>Crisfield, Somerset, Md.</b>		20g. (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>William H. Coulbourn</i>		CHIEF MEDICAL EXAMINER <b>William H. Coulbourn, M.D.</b> DATE SIGNED <b>2-22-59</b>			
EXAMINER'S NAME (Type) <b>William H. Coulbourn, M. D.</b>		DEPUTY MEDICAL EXAMINER <b>FOR SOMERSET COUNTY, MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-22-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lawsonia Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Crisfield, Md.</b>		22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Md.</b>			ADDRESS <b>Bradshaw &amp; Sons, Crisfield, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 27 '59</b>
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

MEDICAL CERTIFICATION

19

2

VS.

4000278xv6

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE  
DEPARTMENT OF HEALTH



1900-1910

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Occupation		Residence		Manner of Death	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
Date of Certificate		Place of Issue		Official Seal	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02302

2308

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN lb <b>Lifetime</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>324 Tyler St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>First RALEIGH Middle GREGORY Last PAIGE</b>		4. DATE OF DEATH <b>February 21, 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 11, 1956</b>
9. AGE (In years last birthday) <b>2 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Crisfield, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Miles</b>		14. MOTHER'S MAIDEN NAME <b>Lucy Paige</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Lucy Paige, 324 Tyler St., Crisfield, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Accidentally burned to death in dwelling fire.</b> 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Body burned to charcoal.</b> (a), stating the underlying cause lost. DUE TO (c) <b>Arms and legs burned off.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL ILLNESS OR INJURY: <b>FOR SOMERSET COUNTY, MD.</b>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Dwelling Fire.</b>	
20c. TIME OF INJURY Month, Day, Year <b>5:00 a.m. 2-21 19 59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Crisfield, Somerset, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>W. H. Coulbourn</b>		DATE SIGNED <b>2-22-59</b>	
EXAMINER'S NAME (Type) <b>William H. Coulbourn, M. D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-22-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lawsonia Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE FEB 27 '59</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>	

MEDICAL CERTIFICATION

19

2

23



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

02303

2315

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kingston</b>				c. LENGTH OF STAY IN 1b <b>Lifetime</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kingston</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RFD, Marion</b>				d. STREET ADDRESS <b>RFD, Marion</b>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>LUKE</b> Middle <b>G.</b> Last <b>ROLLEY</b>				4. DATE OF DEATH Month <b>February</b> , Day <b>4</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 26, 1900</b>	
9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seafood Worker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Oyster &amp; Crab</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>George Rolley</b>				14. MOTHER'S MAIDEN NAME <b>Cora Taylor</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>		17. INFORMANT Address <b>Margie Rolley, Box 216, Marion, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>490x</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>1/19/59</b> <b>15 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 19, 1959</b> , to <b>Feb 4, 1959</b> , that I last saw the deceased alive on <b>Feb 3, 1959</b> , and that death occurred at <b>12:30 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Eldon G. Marksman</b> M.D.				ADDRESS (Street, city or town, state) <b>Princess Anne, Md.</b> DATE SIGNED <b>2/6/59</b>			
PHYSICIAN'S NAME (Type) <b>E. G. Marksman, M. D.</b>				<b>Princess Anne, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-7-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Marumsco Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>RFD, Marion, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Bradshaw &amp; Sons, Crisfield, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02304

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>		c. LENGTH OF STAY IN 1b <b>LIFETIME</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>204 N. FIRST ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EARL</b> First <b>THOMAS</b> Middle <b>GILBERT</b> Last <b>STERLING</b>		4. DATE OF DEATH <b>FEB. 16 1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT. 29, 1913</b>
9. AGE (In years last birthday) <b>45</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SEAFOOD DEALER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CRABS &amp; OYSTERS</b>	11. BIRTHPLACE (State or foreign country) <b>CRISFIELD, MD.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>LON STERLING</b>	
14. MOTHER'S MAIDEN NAME <b>BEATRICE MC CREADY</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give year or dates of service) <b>WW II</b>	
16. SOCIAL SECURITY NO. <b>577-20-1160</b>		17. INFORMANT <b>MRS. BETTY H. STERLING--</b> Address <b>204 N. First St. Crisfield, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Acute Myocardial Infarction</b> DUE TO (b) <b>Coronary Arteriosclerosis &amp; Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>481.1 Influenza, respiratory type</b>			INTERVAL BETWEEN ONSET AND DEATH <b>few min.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>10/17</b> 19 <b>52</b> , to <b>2/16</b> 19 <b>59</b> , that I lost saw the deceased alive on <b>2/14</b> 19 <b>59</b> , and that death occurred at <b>7:35 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. N. BARR, M. D.</b> M. D.		ADDRESS (Street, city or town, state) <b>Crisfield, Md.</b> DATE SIGNED <b>2/19/59</b>	
PHYSICIAN'S NAME (Type) <b>A. N. BARR, M. D.</b>		<b>CRISFIELD, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>FEB. 19, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>SUNNYRIDGE CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>CRISFIELD, MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>BRADSHAW &amp; SONS--CRISFIELD, MD.</b> ADDRESS		24a. REC'D BY REGISTRAR <b>FEB 25 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Threlk</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by a funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2316

## CERTIFICATE OF DEATH

02305

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>				c. LENGTH OF STAY IN 1b <b>1 DAY</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EDW. W. MCCREADY MEMORIAL HOSP</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>BONNIE</b> Middle <b>SUE</b> Last <b>SWIFT</b>				4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>11</b> Year <b>19 59</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-6-59</b>		9. AGE (In years last birthday) yrs. <b>1</b> Months <b>5</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>CRISFIELD, MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>ELWOOD SWIFT, JR.</b>			
14. MOTHER'S MAIDEN NAME <b>CLAUDETTE WILKINS</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service) <b>None</b>			
16. SOCIAL SECURITY NO. <b>NONE</b>				17. INFORMANT Address <b>CLAUDETTE W. SWIFT 102 N FIRST ST.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO <b>493X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b> 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19____, to <b>FEB. 11</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>FEB 11</b> , 19 <b>59</b> , and that death occurred at <b>6:45P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crisfield, Md.</b> DATE SIGNED ACTUAL SIGNATURE <b>C. G. Rawley</b> M.D. PHYSICIAN'S NAME (Type) <b>C. G. RAWLEY, M.D.</b> <b>CRISFIELD, MARYLAND</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-13-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Park</b>		22d. LOCATION (City, town, or county) (State) <b>Crisfield, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Maryland</b> ADDRESS				24a. REC'D BY REGISTRAR DATE <b>FEB 17 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

CERTIFICATE OF DEATH

14-

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. OCCUPATION		6. MARITAL STATUS	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESS		15. SIGNATURE OF CORONER	
16. SIGNATURE OF JURY		17. SIGNATURE OF JUDGE		18. SIGNATURE OF CLERK	
19. SIGNATURE OF SHERIFF		20. SIGNATURE OF DEPUTY SHERIFF		21. SIGNATURE OF CONSTABLE	
22. SIGNATURE OF JAILER		23. SIGNATURE OF PRISONER		24. SIGNATURE OF WARDEN	
25. SIGNATURE OF CHIEF OF POLICE		26. SIGNATURE OF DETECTIVE		27. SIGNATURE OF PATROLMAN	
28. SIGNATURE OF STREET CARRIER		29. SIGNATURE OF MESSENGER		30. SIGNATURE OF MESSENGER	
31. SIGNATURE OF MESSENGER		32. SIGNATURE OF MESSENGER		33. SIGNATURE OF MESSENGER	
34. SIGNATURE OF MESSENGER		35. SIGNATURE OF MESSENGER		36. SIGNATURE OF MESSENGER	
37. SIGNATURE OF MESSENGER		38. SIGNATURE OF MESSENGER		39. SIGNATURE OF MESSENGER	
40. SIGNATURE OF MESSENGER		41. SIGNATURE OF MESSENGER		42. SIGNATURE OF MESSENGER	
43. SIGNATURE OF MESSENGER		44. SIGNATURE OF MESSENGER		45. SIGNATURE OF MESSENGER	
46. SIGNATURE OF MESSENGER		47. SIGNATURE OF MESSENGER		48. SIGNATURE OF MESSENGER	
49. SIGNATURE OF MESSENGER		50. SIGNATURE OF MESSENGER		51. SIGNATURE OF MESSENGER	
52. SIGNATURE OF MESSENGER		53. SIGNATURE OF MESSENGER		54. SIGNATURE OF MESSENGER	
55. SIGNATURE OF MESSENGER		56. SIGNATURE OF MESSENGER		57. SIGNATURE OF MESSENGER	
58. SIGNATURE OF MESSENGER		59. SIGNATURE OF MESSENGER		60. SIGNATURE OF MESSENGER	
61. SIGNATURE OF MESSENGER		62. SIGNATURE OF MESSENGER		63. SIGNATURE OF MESSENGER	
64. SIGNATURE OF MESSENGER		65. SIGNATURE OF MESSENGER		66. SIGNATURE OF MESSENGER	
67. SIGNATURE OF MESSENGER		68. SIGNATURE OF MESSENGER		69. SIGNATURE OF MESSENGER	
70. SIGNATURE OF MESSENGER		71. SIGNATURE OF MESSENGER		72. SIGNATURE OF MESSENGER	
73. SIGNATURE OF MESSENGER		74. SIGNATURE OF MESSENGER		75. SIGNATURE OF MESSENGER	
76. SIGNATURE OF MESSENGER		77. SIGNATURE OF MESSENGER		78. SIGNATURE OF MESSENGER	
79. SIGNATURE OF MESSENGER		80. SIGNATURE OF MESSENGER		81. SIGNATURE OF MESSENGER	
82. SIGNATURE OF MESSENGER		83. SIGNATURE OF MESSENGER		84. SIGNATURE OF MESSENGER	
85. SIGNATURE OF MESSENGER		86. SIGNATURE OF MESSENGER		87. SIGNATURE OF MESSENGER	
88. SIGNATURE OF MESSENGER		89. SIGNATURE OF MESSENGER		90. SIGNATURE OF MESSENGER	
91. SIGNATURE OF MESSENGER		92. SIGNATURE OF MESSENGER		93. SIGNATURE OF MESSENGER	
94. SIGNATURE OF MESSENGER		95. SIGNATURE OF MESSENGER		96. SIGNATURE OF MESSENGER	
97. SIGNATURE OF MESSENGER		98. SIGNATURE OF MESSENGER		99. SIGNATURE OF MESSENGER	
100. SIGNATURE OF MESSENGER		101. SIGNATURE OF MESSENGER		102. SIGNATURE OF MESSENGER	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2317  
CERTIFICATE OF DEATH

Reg. Dist. No.

92306

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EDW. W. MCCREADY MEMO. HOSP.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BLANCHE</b> Middle <b>O.</b> Last <b>WARD</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>1</b> Year <b>19 59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-28-1895</b>
9. AGE (In years last birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR: Months <b>63</b> Days <b>1</b> Hours <b>19</b> Min. <b>59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>THOMAS WARD</b>		14. MOTHER'S MAIDEN NAME <b>ALICE HORNER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>MURRAY E. WARD,</b> Address <b>CRISFIELD, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>174X</b> <b>reflex indigestion</b> DUE TO <b>2 yrs.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>reflex indigestion</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 30, 1959</b> , to <b>Feb 1, 1959</b> that I last saw the deceased alive on <b>Feb 1, 1959</b> , and that death occurred at <b>1:15 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>CRISFIELD, Md.</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Sarah M. Peyton</b> M.D. <b>CRISFIELD, Md.</b>			
PHYSICIAN'S NAME (Type) <b>SARAH M. PEYTON, M.D., CRISFIELD, MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-4-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Park</b>	22d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Md.</b> ADDRESS		24a. REC'D BY REGISTRAR <b>FEB 4 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

• 4001 • 0722 • 0411 • 0001 •

growth

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2318

CERTIFICATE OF DEATH

Reg. Dist. No.

02307

1. PLACE OF DEATH o. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marion Station</u>		c. LENGTH OF STAY IN 1b <u>84</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph</u> First <u>H.</u> Middle <u>Ward</u> Last		4. DATE OF DEATH Month <u>Feb.</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 22, 1884</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Hopewell</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hiram Ward</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Steward</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>217-05-4082</u>	
17. INFORMANT <u>Mrs. Annie Davish-Marion Stz, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dehydration &amp; Electrolyte imbalance</u> 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of prostate</u> DUE TO (c) <u>18 mths.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/15</u> , 19 <u>58</u> , to <u>2/27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2/27/59</u> , 19 <u>59</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Cecil A. Duverney</u> M.D.		ADDRESS (Street, city or town, state) <u>11 S. 4th Street, Crisfield, Md.</u>	
PHYSICIAN'S NAME (Type) <u>CECIL A. DUVERNEY</u>		DATE SIGNED <u>2/27/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/3/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hopewell</u>		22d. LOCATION (City, town, or county) (State) <u>Crisfield, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ward</u> ADDRESS <u>Marion Sta., Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 6 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JAN 10 1915	
AGE		SEX	
65		M	
MARRIED		OCCUPATION	
W		FARMER	
PLACE OF BIRTH		PLACE OF DEATH	
NEW HAMPSHIRE		NEW HAMPSHIRE	
CAUSE OF DEATH		MANNER OF DEATH	
HEART DISEASE		NATURAL	
PERIOD OF ILLNESS		DATE OF BURIAL	
2 WEEKS		JAN 12 1915	
NAME OF PHYSICIAN		NAME OF MINISTER	
DR. J. H. HARRIS		PASTOR J. H. HARRIS	
NAME OF FUNERAL HOME		NAME OF CEMETERY	
J. H. HARRIS		J. H. HARRIS	
NAME OF REGISTRAR		NAME OF CLERK	
J. H. HARRIS		J. H. HARRIS	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2319

## CERTIFICATE OF DEATH

Reg. Dist. No.

02308

1. PLACE OF DEATH o. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Nancy</b> First <b>Estelle</b> Middle <b>Warwick</b> Last		4. DATE OF DEATH <b>Feb.</b> Month <b>13</b> , Day <b>19</b> , Year <b>59</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 28, 1867</b>
9. AGE (In years last birthday) <b>91</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>James U. Warwick</b>		14. MOTHER'S MAIDEN NAME <b>Mary G. Lankford</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Miss Margaret Brereton: Princess Anne</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Senility</b> DUE TO (c) <b>Secondary Anemia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs</b> <b>20 yrs</b> <b>15-20 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 15, 1955</b> to <b>Feb 13, 1959</b> , that I last saw the deceased alive on <b>Feb 12, 1959</b> , and that death occurred at <b>1:10 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. C. Lewis</b>		ADDRESS (Street, city or town, state) <b>Princess Anne, Md</b>	
PHYSICIAN'S NAME (Type) <b>A. C. Lewis, M.D.</b>		DATE SIGNED <b>2/15/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/15/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Warwick Family</b>		22d. LOCATION (City, town, or county) (State) <b>Rural Princess Anne, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James L. Luman</b>		ADDRESS <b>Princess Anne, Md</b>	
24a. REC'D BY REGISTRAR <b>FEB 25 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEATH RECORD  
1910

WILLIAM BOLM

CERTIFICATE OF DEATH

2319

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

Name of Deceased		WILLIAM BOLM	
Date of Death		JAN 10 1910	
Place of Death		BALTIMORE, MD.	
Age		62	
Sex		Male	
Race		White	
Marital Status		Married	
Occupation		Carpenter	
Cause of Death		Heart Disease	
Signature of Physician		J. H. B. [Signature]	
Signature of Registrar		[Signature]	
Date of Registration		JAN 10 1910	
Place of Registration		BALTIMORE, MD.	
Signature of Deceased		[Signature]	
Signature of Next of Kin		[Signature]	
Signature of Burial Officer		[Signature]	
Date of Burial		JAN 10 1910	
Place of Burial		BALTIMORE, MD.	
Signature of Minister		[Signature]	
Date of Interment		JAN 10 1910	
Place of Interment		BALTIMORE, MD.	
Signature of Undertaker		[Signature]	
Date of Embalming		JAN 10 1910	
Place of Embalming		BALTIMORE, MD.	
Signature of Embalmer		[Signature]	
Date of Autopsy		JAN 10 1910	
Place of Autopsy		BALTIMORE, MD.	
Signature of Pathologist		[Signature]	
Date of Postmortem		JAN 10 1910	
Place of Postmortem		BALTIMORE, MD.	
Signature of Coroner		[Signature]	
Date of Inquest		JAN 10 1910	
Place of Inquest		BALTIMORE, MD.	
Signature of Juror		[Signature]	
Date of Verdict		JAN 10 1910	
Place of Verdict		BALTIMORE, MD.	
Signature of Judge		[Signature]	
Date of Judgment		JAN 10 1910	
Place of Judgment		BALTIMORE, MD.	
Signature of Clerk		[Signature]	
Date of Record		JAN 10 1910	
Place of Record		BALTIMORE, MD.	
Signature of Registrar		[Signature]	
Date of Certificate		JAN 10 1910	
Place of Certificate		BALTIMORE, MD.	

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
2320 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02309

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home</u>				d. STREET ADDRESS <u>R.F.D. # 1 Box 34</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Emalee</u> Middle <u>Waters</u> Last				4. DATE OF DEATH <u>February 3</u> 19 <u>59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 6, 1885</u>		9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Employed</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lorenzo Waters</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Waters, Pocomoke City, Md.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>James Waters, Pocomoke City, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)							INTERVAL BETWEEN ONSET AND DEATH Years
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>R. H. Johnson</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>R. H. Johnson</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/7/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Unionville Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke City, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - New Church, Va.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR DATE  
FILED

MASSACHUSETTS DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF ATTENDING PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF WITNESSES		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF BURIAL PLACE	
19. SIGNATURE OF CEMETERY		20. SIGNATURE OF INTERVIEWER		21. SIGNATURE OF REPORTER	
22. SIGNATURE OF CLERK		23. SIGNATURE OF RECORDER		24. SIGNATURE OF INDEXER	
25. SIGNATURE OF ARCHIVER		26. SIGNATURE OF DISTRIBUTOR		27. SIGNATURE OF DELIVERER	
28. SIGNATURE OF MAILER		29. SIGNATURE OF POSTER		30. SIGNATURE OF FILER	
31. SIGNATURE OF CLERK		32. SIGNATURE OF RECORDER		33. SIGNATURE OF INDEXER	
34. SIGNATURE OF ARCHIVER		35. SIGNATURE OF DISTRIBUTOR		36. SIGNATURE OF DELIVERER	
37. SIGNATURE OF MAILER		38. SIGNATURE OF POSTER		39. SIGNATURE OF FILER	
40. SIGNATURE OF CLERK		41. SIGNATURE OF RECORDER		42. SIGNATURE OF INDEXER	
43. SIGNATURE OF ARCHIVER		44. SIGNATURE OF DISTRIBUTOR		45. SIGNATURE OF DELIVERER	
46. SIGNATURE OF MAILER		47. SIGNATURE OF POSTER		48. SIGNATURE OF FILER	
49. SIGNATURE OF CLERK		50. SIGNATURE OF RECORDER		51. SIGNATURE OF INDEXER	
52. SIGNATURE OF ARCHIVER		53. SIGNATURE OF DISTRIBUTOR		54. SIGNATURE OF DELIVERER	
55. SIGNATURE OF MAILER		56. SIGNATURE OF POSTER		57. SIGNATURE OF FILER	
58. SIGNATURE OF CLERK		59. SIGNATURE OF RECORDER		60. SIGNATURE OF INDEXER	
61. SIGNATURE OF ARCHIVER		62. SIGNATURE OF DISTRIBUTOR		63. SIGNATURE OF DELIVERER	
64. SIGNATURE OF MAILER		65. SIGNATURE OF POSTER		66. SIGNATURE OF FILER	
67. SIGNATURE OF CLERK		68. SIGNATURE OF RECORDER		69. SIGNATURE OF INDEXER	
70. SIGNATURE OF ARCHIVER		71. SIGNATURE OF DISTRIBUTOR		72. SIGNATURE OF DELIVERER	
73. SIGNATURE OF MAILER		74. SIGNATURE OF POSTER		75. SIGNATURE OF FILER	
76. SIGNATURE OF CLERK		77. SIGNATURE OF RECORDER		78. SIGNATURE OF INDEXER	
79. SIGNATURE OF ARCHIVER		80. SIGNATURE OF DISTRIBUTOR		81. SIGNATURE OF DELIVERER	
82. SIGNATURE OF MAILER		83. SIGNATURE OF POSTER		84. SIGNATURE OF FILER	
85. SIGNATURE OF CLERK		86. SIGNATURE OF RECORDER		87. SIGNATURE OF INDEXER	
88. SIGNATURE OF ARCHIVER		89. SIGNATURE OF DISTRIBUTOR		90. SIGNATURE OF DELIVERER	
91. SIGNATURE OF MAILER		92. SIGNATURE OF POSTER		93. SIGNATURE OF FILER	
94. SIGNATURE OF CLERK		95. SIGNATURE OF RECORDER		96. SIGNATURE OF INDEXER	
97. SIGNATURE OF ARCHIVER		98. SIGNATURE OF DISTRIBUTOR		99. SIGNATURE OF DELIVERER	
100. SIGNATURE OF MAILER		101. SIGNATURE OF POSTER		102. SIGNATURE OF FILER	



**CYANIDE**



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

02311

2322

1. PLACE OF DEATH o. COUNTY <b>SOMERSET</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>		c. LENGTH OF STAY IN 1b <b>69 YRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EDW. W. MCCREADY MEMO. HOSP.</b>		d. STREET ADDRESS <b>ASBURY AVENUE</b>	
3. NAME OF DECEASED (Type or print) <b>HORACE</b>		4. DATE OF DEATH <b>FEBRUARY 20 1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-16-1890</b>
9. AGE (In years last birthday) <b>69</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RAILWAY EXPRESS</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>NED WILSON</b>		14. MOTHER'S MAIDEN NAME <b>FLORENCE DARBY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>714-03-4195</b>	
17. INFORMANT <b>MARY E. SUAREZ, CRISFIELD, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary infarction - pulmonary</b> <b>420.1</b> DUE TO <b>coronary embolus - infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Anteriorly located myocardial infarction</b> DUE TO (c) <b>antemortem</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b> <b>2 mo.</b> <b>?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1959, to Feb 20, 1959, that I last saw the deceased alive on Feb 19, 1959, and that death occurred at 6:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>CRISFIELD, MARYLAND</b> DATE SIGNED <b>2/20/59</b>			
ACTUAL SIGNATURE <b>Sarah M. Peyton</b> M.D.		PHYSICIAN'S NAME (Type) <b>SARAH M. PEYTON, M.D.</b> <b>CRISFIELD, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 22, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 25 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kneass</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

